Assembly Select Committee on Alcohol and Drug Abuse
The Honorable Jim Beall Jr., Chair
Testimony from the California Department of Alcohol and Drug Programs (ADP)
Renée Zito, Director

Introduction

Good morning. My name is Renée Zito, Director of the California Department of Alcohol and Drug Programs (ADP). I am pleased to have the opportunity to speak to the Assembly Select Committee on Alcohol and Drug Abuse and to provide the written testimony contained herein. I appreciate the mission of the Select Committee and intend to assist the Committee in identifying the extent of the problem in California, its costs to society and the State, and in identifying possible improvements to our programs and the clients they serve.

Last month, the Select Committee presented several questions to guide ADP in its written testimony (Attachment A). These questions cover the scope of the substance abuse problem in California (including information on specific data and how clients are tracked), the availability and access to substance abuse treatment slots, the barriers and gaps in services, an overview of substance abuse programs, and an explanation of screening tools and criteria. ADP has made every effort to address these questions within our testimony and to provide an overview of ADP's programs and services.

Scope of substance abuse in California

Coordination of demographic statistics and programs with the Departments of Mental Health (DMH), Social Services (DSS) and Corrections and Rehabilitation (CDCR)

Demographic statistics:

Ongoing coordination and analysis of demographic data between multiple departments such as the Department of Mental Health or Social Services requires specific approval for the creation of cross-program data linkages due to privacy protections and limitations on use of data under current state and federal law. Ad hoc linkages have occurred for specific program evaluations and analyses, however, these efforts historically are limited to specific projects agreed to by all participating departments. Most such projects require review by the California Health and Human Services Agency Committee for the Protection of Human Subjects.

ADP does collect limited data through the California Outcomes Measurement System (CalOMS). Substance abuse treatment programs are required to collect admission and certain outcome information for CalOMS. CalOMS data includes elements that identify the CalWORKs, MediCal, mental health, and criminal justice status of ADP clients at the time of program entry. CalOMS also has information about the referral source for ADP treatment programs, which allows ADP to collect data on the numbers of referrals from probation or parole officers, drug court programs, dependency court programs, child protective services, schools, employers, or health care providers.

Program coordination:

Through a Memorandum of Understanding with DMH, ADP is identifying opportunities to serve clients with Co-Occurring Disorders (COD) using programs and funds established within the Mental Health Services Act (MHSA). In 2005, ADP and DMH convened the Co-Occurring Disorders Joint Action Committee (COJAC) to provide a forum for collaboration among affected departments and stakeholders.

ADP is working in collaboration with DMH on the initial development and implementation of an Action Plan to address COD. The Action Plan (see Attachment B) was completed in September 2005. Strategies within the Action Plan include, but are not limited to, building a framework to support enhanced capacity for COD clients, identifying potential funding sources for programs designed to reach specific populations, providing technical assistance to counties on how to address COD, identifying screening tools, developing tools for monitoring programs and outcomes, and working with housing agencies to reduce homelessness among the COD population.

The ADP Office of Criminal Justice Collaboration (OCJC) oversees three programs that engage in continuous collaboration with DMH, DSS and CDCR on criminal justice-related alcohol and drug treatment issues. Drug treatment services provided for parolees referred under the Substance Abuse and Crime Prevention Act of 2000 (SACPA) are coordinated closely with the CDCR Division of Adult Parole Operations. CDCR provides funding to ADP to provide AOD placement assistance to CDCR clientele through the Parolee Services Network, which provides community-based AOD treatment and recovery services.

ADP collaborates with DSS to serve families struggling with drug addiction through the Dependency Drug Court Program. ADP works with DSS to review county plans and to coordinate reporting needs.

<u>Structure for meeting California's needs in the Public and Private Sector</u>

ADP's substance abuse treatment service delivery system ensures that all Californians have access to quality care (treatment); protects the health and safety of patients and the general public; and educates the public that substance abuse is a chronic condition that can be successfully prevented and treated. Public alcohol and other drug (AOD) prevention, treatment, and recovery services in California are provided through a partnership between ADP and the counties. An annual County Plan and Negotiated Net Amount Contract identifies the services planned in each county. Counties, depending on local needs, provide for a continuum of services that include client-centered, culturally appropriate prevention, intervention and treatment and recovery services. The treatment service array includes nonresidential, narcotic treatment, residential, and recovery support services.

ADP licenses and certifies AOD residential and outpatient programs, methadone treatment programs, and programs providing federal Medicaid reimbursable services for eligible individuals. The services are delivered primarily through community-based

service providers. Treatment providers can either be under contract with counties to provide publicly-funded AOD services or may offer a private-pay service. In addition, a limited number of methadone and Drug Medi-Cal treatment providers are under direct contract with ADP.

AOD programs serve anyone seeking substance abuse treatment. However, individual programs may be gender-specific, serve only pregnant and parenting woman, serve parolees, or concentrate on a specific ethnic group.

ADP works closely with its primary stakeholders to determine the methodology for allocating funds and to obtain AOD program policy input from constituent groups. The primary groups include the Director's Advisory Council, the Offender Treatment Advisory Group, the County Alcohol and Drug Program Administrator's Association of California (CADPAAC) and the Fiscal Workgroup. ADP also convenes ad hoc groups to address specific issues.

Health and Safety Code Section 11814 requires ADP to allocate State and federal funds based on the population of each county. State law requires ADP to assure that counties with a population under 100,000 receive a minimum allocation of funds for the provision of services, and that each county receives, at minimum, an allocation equal to that received in Fiscal Year (FY) 1984-85. ADP allocates ongoing funds at historical level. If additional general funds are made available, ADP utilizes a base allocation of $2,500 per $1 million increase with the remainder allocated based on population. For funds with a specific purpose, ADP develops and utilizes allocation methodologies that meet the intent of the funds.

Data Requests

Percentage of Population identified with a substance abuse problem:

The National Survey on Drug Use and Health (NSDUH) administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) provides estimates of the percentage of Californians identified as having an alcohol or illicit drug dependence or abuse problem. The NSDUH collects information on those ages 12 and above. To provide a sufficient sample for California specific estimates, two years of NSDUH survey data must be combined. The latest estimates are based on 2004 and 2005 NSDUH data:

- Of Californians age 12 and above, 9.3 percent have an alcohol or illicit drug dependence or abuse problem. Alcohol abuse or dependence is more common than abuse or dependence on any other drug. By age group, the percentages are as follows:
    - Ages 12 to 17; 8.6 percent.
    - Ages 18 to 25; 20.7 percent.
    - Age 26 and older; 7.4 percent.

Funding for public and private substance abuse treatment services:

For FY 2006-07, ADP estimates that a total of $593,883,000 will be expended to provide publicly funded alcohol and other drug (AOD) treatment services. Of this amount, $533,240,000 will be for regular AOD treatment services and $49,643,000 will be for perinatal AOD treatment services. This estimated amount includes both local assistance and state support expenditures.

ADP does not have the ability to estimate privately funded AOD treatment services.

Data on California Population in need of substance abuse services:

The latest California estimates are based on 2004 and 2005 NSDUH data and are as follows:

- Approximately 2.9 percent of Californians age 12 and above need, but are not receiving treatment for illicit drug use in the past year. By age group, the percentage of Californians needing, but not receiving treatment for illicit drug use were as follows:
    - Ages 12 to 17; 5.2 percent.
    - Ages 18 to 25; 8.0 percent.
    - Age 26 and older; 1.7 percent.
- Approximately 7.5 percent of Californians age 12 and above needed, but were not receiving, treatment for alcohol use in the past year. By age group, the percentage of Californian needing, but not receiving, treatment for alcohol use were as follows:
    - Ages 12 to 17; 5.6 percent.
    - Ages18 to 25; 16.7 percent
    - Ages 26 and older; 6.2 percent.

It is important to note that there are a variety of reasons why a certain percentage of the population needing AOD services are not receiving them at this time. While estimates specific to California are not available, national data from the 2005 NSDUH also provides information regarding respondents' next steps in seeking treatment. Of the respondents needing, but not receiving treatment, 94.4 percent did not feel they needed treatment; 4.1 percent felt they needed treatment but did not make an effort to get it; and only 1.4 percent felt they needed treatment and made an effort to get it.

For those that felt they needed treatment, and made an effort to receive treatment, the four most often reported reasons for not receiving treatment were "cost or insurance barriers" (44.4%); "other access barriers" (21.2%); "not ready to stop using" (21.1%); and "stigma" (18.5%).

Among those who made no effort to receive treatment, 45.3 percent reported they were not ready to stop using, 31 percent reported cost and insurance barriers and 26.3 percent reported stigma as reasons for not receiving treatment.

Treatment Program Admissions

During State Fiscal Year 2005/2006 a total of 153,365 unique clients were admitted to non-detoxification treatment services. In addition, 27,486 unique clients entered detoxification services.

Average wait time prior to enrollment in a program

In 2006, ADP began collecting information on how long people wait before receiving treatment services through the CalOMS data system. Data collected statewide through August 1, 2007, is available for analysis. While most clients receive treatment services with little wait, time varies by service modality as shown in the following table:

Table One. Days Waited to Receive Services by Service Modality*

Service Modality	Days Waited to Receive Services						Total
	Zero Days	1 to 3	4 to 6	7 to 9	10 to 30	31 or More	
Detoxification Outpatient	11,812	1,652	341	282	380	91	14,558
	81.1	11.4	2.3	1.9	2.6	0.6	100.0
Detoxification Residential	24,931	4,977	1,580	1,194	2,557	355	35,594
	70.0	14.0	4.4	3.4	7.2	1.0	100.0
Narcotic Replacement Treatment	15,451	1,455	423	272	377	106	18,084
	85.4	8.1	2.3	1.5	2.1	0.6	100.0
Outpatient Intensive Treatment	12,926	1,064	429	363	714	149	15,645
	82.6	6.8	2.7	2.3	4.6	1.0	100.0
Outpatient Treatment	119,092	11,746	6,498	6,702	12,458	2,939	159,435
	74.7	7.4	4.1	4.2	7.8	1.8	100.0
Residential Treatment (30 Days or Less)	3,051	501	250	213	616	314	4,945
	61.7	10.1	5.1	4.3	12.5	6.4	100.0
Residential Treatment (31 Days or More)	23,665	8,257	3,754	3,549	9,341	3,975	52,541
	45.0	15.7	7.1	6.8	17.8	7.6	100.0
Total	210,928	29,652	13,275	12,575	26,443	7,929	300,802
	70.1	9.9	4.4	4.2	8.8	2.6	100.0

* CalOMS data as of August 1, 2007

ADP collects information via its Drug and Alcohol Treatment Access Report (DATAR) in order to identify specific categories of individuals awaiting publicly-funded treatment and the availability of treatment facilities for these individuals. DATAR data shows that, on any given day approximately 6,000 persons are on treatment service waiting lists statewide.

Priorities or preferences for wait-listed individuals

Treatment programs receiving federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funding are required to give preference in treatment to pregnant women who seek or are referred for services: Pregnant women who are referred for treatment are to be referred to an AOD program with the capacity to provide services to the referred woman. If such a program is not available, the pregnant client is to receive interim services, including a referral for prenatal care and counseling on the effects of alcohol and drug use on the fetus, within 48 hours of seeking treatment.
Programs serving an injecting drug abuse population are to provide preference to treatment in the following sequence: a) pregnant injecting drug users, b) pregnant substance abusers, c) injecting drug users, and d) all others. Intravenous drug abusers seeking treatment must receive treatment within 14 days or interim services within 48 hours. If intravenous drug abusers receive interim services, a treatment placement must be provided within 120 days.

At a minimum, interim services include counseling and education about HIV and tuberculosis (TB), counseling and education about the risks of needle sharing, counseling and education about the risks of transmission to sexual partners and infants, and counseling and education about steps that can be taken to ensure that HIV and TB transmission does not occur as well as referral for HIV and TB treatment services if necessary.

ADP requires interim services to be made available to all seeking treatment from programs receiving block grant funding.

Prenatal exposure and the need for services among pregnant women

According to NSDUH estimates, approximately one million women in California had an unmet treatment need at the time of the survey sample. Separate estimates on the percentage of pregnant women in need of, but not receiving, AOD treatment are not available through NSDUH.

In FY 2005-06, 57,587 women were admitted to non-detoxification treatment services, and 8,177 women were admitted to detoxification services during. In FY 2005-06, 3,686 pregnant women entered non-detoxification treatment services, and 185 pregnant women were admitted into detoxification services. During that same year, Approximately 100,000 infants were born with substance exposure. An estimated 848,670 children lived with a parent who had a substance use disorder, while only 103,158 parents were admitted to treatment.

Barriers and Gaps in Service

Youth Treatment

The 2003-2004 National Survey on Drug Use and Health found that at least 188,000 California adolescents (ages 12-17) have a substance abuse problem requiring treatment. The 2005-2006 California Student Survey confirmed that at least 10 percent of all 9th through 12th graders (approximately 193,700 students) need treatment. Approximately 17,000 youth received alcohol and other drug (AOD) abuse treatment in 2006; consequently, less than ten percent of the adolescents in need received treatment in the publicly-funded AOD system in Calendar Year 2006. While a majority of adolescents in treatment are boys (65 percent male versus 35 percent female), research has shown that girls are using substances at earlier ages and that girls suffer consequences, including unplanned pregnancy and an emotional toll beyond that experienced by boys.

The critical differences between youth and adult AOD-related problems require adolescent programs to employ specialized staffing, take additional safety precautions, and offer a wider range of services to address a variety of life issues.

Providing enhanced services to youth is more expensive than adult treatment, yet, the bulk of AOD treatment programs and funding are designated for adults. Programs such as Drug Medi-Cal (DMC), Early and Periodic Screening Diagnosis and Treatment (EPSDT), and Healthy Families offer limited services.

ADP and the departments within the California Health and Human Services Agency are taking the following steps toward closing the gaps in youth services:

As of August 2007, ADP will have completed a three-year federal demonstration grant project in which nearly 10,000 youth between the ages of 12 and 20 received AOD services through the California Access to Recovery (CARE) Program. ADP has applied for, and is now awaiting notification of, a three-year continuation of CARE funding which would expand services into smaller rural counties.

With the cooperation of youth treatment experts in the field, ADP has published a set of *Youth Treatment Guidelines* to be used as a blueprint for serving adolescent AOD clients.

The Healthy Families Program (HFP) offers low cost health insurance coverage to children who do not have private insurance and do not qualify for no-cost Medi-Cal. All 23 HFP plans provide AOD services. In 2006 HFP served 1,468 youth in need of AOD services. The Managed Risk Medical Insurance Board (MRMIB) recently contracted for an evaluation of AOD services provided by the HFP plans. The final phase of this evaluation will be completed in the summer of 2009. Results may be used to provide incentives to plans to achieve desired outcomes.

Women's Treatment and Prevention

More than 100,000 infants are born each year in California who have been prenatally exposed to alcohol. There is an ongoing need to educate women of childbearing age that there is no safe amount of alcohol that can be consumed during pregnancy. Fewer than 4,000 pregnant women enter treatment each year.

Over a million women would have benefited from but did not receive treatment for alcohol and drug problems. Of these, only 63,000 were admitted to treatment.

Gender responsive treatment addresses the needs of women with substance use disorders. While over 300 perinatal programs, serving approximately 30,000 women per year in California, provide gender responsive treatment, the majority of women are served in programs that do not offer a woman-specific program or group.

Substance Abuse Screening and Brief Intervention (SBI)

ADP oversees the California Screening, Brief Intervention, Referral, and Treatment (CASBIRT) program, a federally-funded project in San Diego County providing SBIRT services for individuals entering trauma centers, emergency rooms, and neighborhood health clinics. Health Educators use a validated screening tool to assess an individual's risk for developing substance use problems and, if necessary, provide brief intervention services or referral to treatment.

Effective January 2007, the Centers for Medicare and Medicaid Services (CMS) approved new billing codes allowing reimbursement for alcohol and drug screening and brief intervention (SBI). ADP is working with the Department of Health Care Services' (DHCS) in their consideration of adopting the SBI - HCPCS codes for Medi-Cal eligible clients in California.

Co-Occurring Disorders (COD)

Data drawn from convenience samples obtained in studies conducted in the 1980s to the mid-1990s have provided the mental health and AOD fields with figures on the prevalence of co-occurring mental health and substance abuse disorders. Of these studies (summarized by Sacks et al., 1997), those conducted in mental health settings found 20 to 50 percent of mental health clients had a lifetime co-occurring substance use disorder, while those conducted in substance abuse treatment agencies found 50 to 75 percent of their clients had a lifetime co-occurring mental disorder.

Of the COD cases reported in substance abuse settings; a substantial proportion either had a mental disorder of low severity or an antisocial personality disorder. Substance abuse treatment has been found to be effective for clients with a low-severity mental health disorder, and is widely acknowledged as the treatment of choice for COD clients with antisocial personality disorder. Studies also suggest elevated rates of other forms of mental disorders among clients in substance abuse settings, including major depressive disorder and other mood or affective disorders, or Post Traumatic Stress Disorder (PTSD). The diagnosis of more than one mental disorder is not unusual.

Currently, mental health services in California are limited to clients with severe mental illness (SMI) and are not readily available to address those mental health disorders that generally accompany AOD clients.

For the past ten years, ADP and DMH have worked in collaboration to eliminate barriers to the provision of services to persons with the co-occurring disorders of mental illness and substance use. That cooperative effort led to the sponsorship of COD Workgroup in 2002, which efforts resulted in the COD Workgroup Final Report released in June 2004 and a State Action Plan in 2005. An ongoing Co-Occurring Joint Action Council (COJAC) brings representation from ADP, DMH, and other stakeholders together to facilitate moving the action plan forward with the deepest and broadest input possible.

Starting this year, funding from the Mental Health Services Act (MHSA), also known as Proposition 63, will support a variety of county-level Prevention and Early Intervention (PEI) programs. These funds are of particular interest to AOD treatment and prevention stakeholders. Unlike most MHSA funding, PEI funds may be used to provide services to a wide range of individuals vulnerable to mental illness, not just those with SMI. Statewide, counties will receive approximately $40-$60 million dollars for PEI programs.

Substance Abuse Programs Funded through ADP

Prevention

Many providers in California receive local, state, or federal funding to conduct substance-related prevention activities. As of June 30, 2007, there were 268 active county and private prevention providers that received federal Substance Abuse Prevention and Treatment block grant funds through ADP for conducting one or more of the following six prevention strategies:

1. *Information Dissemination:* One-way communication to an audience that provides awareness and knowledge of the nature and extent of alcohol, tobacco, and other drug (ATOD) use, abuse, and addiction; their effects on individuals, families, and communities; and increases knowledge and provides awareness of available prevention programs and services. Approximately 83 percent of all SAPT block grant-funded prevention providers engaged in services under this strategy.

2. *Education:* Two-way communication to enhance individual efforts to remain free of alcohol and other drugs (AOD). Approximately 85 percent of all SAPT block grant-funded prevention providers engaged in services under this strategy.

3. *Alternatives:* Provides for the participation of target populations in activities that exclude ATOD use. This strategy assumes that constructive and healthy activities offset the attraction to or otherwise meet the needs usually filled by ATOD and would therefore minimize or remove the need to use these substances. These programs redirect individuals from potentially problematic settings and activities to situations free from AOD influence. Approximately 58

percent of all SAPT block grant-funded prevention providers engaged in services under this strategy.

4. *Problem Identification and Referral:* Identifies those individuals who have engaged in illegal/age-inappropriate use of tobacco or alcohol or their first use of illicit drugs, then assesses whether their behavior can be reversed through education. This strategy excludes any screening to determine if a person is in need of treatment. Approximately 36 percent of all SAPT block grant-funded prevention providers engaged in services under this strategy.

5. *Community-Based Process:* Enhances the ability of a community to more effectively provide prevention and treatment services for ATOD disorders. Activities may include organizing, planning, and enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking. Approximately 79 percent of all SAPT block grant-funded prevention providers engaged in services under this strategy.

6. *Environmental:* Establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of ATOD abuse in the general population. Approximately 56 percent of all SAPT block grant-funded prevention providers engaged in services under this strategy.

Treatment

California's substance abuse treatment program, whether funded through the State Department of Health Care Services for Medi-Cal-eligible individuals or through ADP, offers the following standard levels of services:

1. *Non-Residential/Outpatient Treatment:* Services provided where the client does not reside in a treatment facility. Outpatient treatment may include individual or group counseling. Outpatient treatment may also include Narcotic Replacement Therapy (NRT), outpatient services that utilize methadone or buprenorphine to help individuals eventually maintain freedom from narcotic dependence. Fiscal Year 2005-06 Cost Reports show that 703 drug-free outpatient (non-intensive) providers and 123 NRT clinic sites received ADP funds.

2. *Day Care Rehabilitative (aka Intensive Outpatient Treatment Services):* Intensive and frequent counseling services that last three or more hours for three or more days per week. FY 2005-06 Cost Reports indicate 203 such providers received funding through ADP.

3. *Residential Treatment:* Drug-free treatment services providing 24 hours per day in a non-medical, structured living environment. Residents receive frequent group and individual counseling and life skills training. FY 2005-06 Cost Reports show 383 residential (non-detoxification) providers received ADP funds.

4. *Detoxification:* Residential and outpatient services designed to support and assist participants undergoing a period of planned withdrawal from AOD

dependence and explore/develop plans for continued service. Prescribed medication may be administered in this type of service, including methadone detoxification, or a social model (drug-free) approach may be taken. FY 2005-06 Cost Reports indicate 68 residential and outpatient detoxification providers received funding through ADP. Many of the over 100 outpatient detoxification clinics received fee-for-service Medi-Cal or private payments rather than ADP funds.

The minimal elements of AOD service include:

- Screening
- Assessment
- Intake and registration procedures
- Routine and random toxicology screening
- Treatment Planning
- Crisis Management
- Pharmacotherapy and medication management
- Individual and group counseling (cognitive behavioral therapy and motivational enhancement, which uses rewards to reinforce desired behaviors, are examples of counseling approaches that have demonstrated success with difficult to treat individuals)
- Education
- Family education and counseling
- Self-help and support group orientation
- Case management
- Recovery maintenance planning and services (12-step programs and other mutual support groups, alumni and other group counseling, and individual face-to-face or telephonic counseling as necessary).

Screening for Substance Abuse Issues

ADP does not screen potential clients for substance abuse issues. Instead, potential clients or their significant others who contact ADP's Resource Center for AOD treatment referrals are given the phone number of the AOD program administrator for the county in which they seek treatment, a number which is listed in local telephone directories under "Government Services." Directly or through a central intake unit, the administrator or a staff member provides information, briefly screens potential clients for substance-related problems using the Michigan Alcohol Screening Test (MAST) or other screening tools, and refers individuals to the most appropriate treatment modality and available AOD-related service provider. Each county has its own referral process. Many counties also receive client referrals from probation officers assigned to courts for Proposition 36 or drug court programs. These clients will have been screened prior to referral.

The most common assessment tools are the Addiction Severity Index (ASI) and the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC). The ASI examines seven biopsychosocial areas: medical status,

employment/support status, alcohol use, drug use, legal status, family/social status, and psychiatric status. The ASAM-PPC addresses six biopsychosocial dimensions: acute intoxication and/or withdrawal potential, biomedical conditions and complications, emotional/behavioral or cognitive conditions and complications, readiness to change, relapse/continued use or continued problem potential, and recovery/living environment.

ADP developed and maintains a web site that provides the public with comprehensive information on over 1,800 licensed or certified treatment/recovery programs in California and a statewide listing of county AOD offices, so individuals can obtain treatment referrals 24 hours a day. ADP funds local affiliates of the National Council on Alcoholism and Drug Dependence, which have staff and trained volunteers to provide information, screening, assessment, and referral services. These agencies are listed in local telephone directories.

Conclusion

As you can see the scope of the problem is significant and there are barriers to service. However, the Department is proud of the significant accomplishments that have been made and also recognize the opportunities that are ahead. We continue to work with our stakeholders and other state agencies to improving the lives of Californians and ensuring healthier, safer communities and a state less burdened by the societal and economic costs of substance abuse.

This concludes my testimony today. I want to thank you for your attention and welcome any questions you might have.